From Clean Air to a Clean Bill of Health: Using Allowance Trading under the Clean Air Act as a Model for Covering All Private-Sector Employees

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Across the political spectrum, there remains widespread agreement that the failure to insure tens of millions of Americans is one of the largest problems facing the U.S. health care system. Unfortunately, the health policy universe of solutions to this problem is predominantly divided into two camps. One relies heavily on direct government intervention in the form of public insurance and regulation of the private insurance market, and the other relies on financial incentives and a reduction in government regulation to stimulate private market forces to "fix" the market. These camps have been dug into their positions for quite some time; this paper seeks to show both sides a way out.

Bridging the Gap between Two Paradigms

In the U.S. health care system, private employers finance most individuals' health insurance policies. Employers, however, are under no obligation to provide health insurance for their employees. In fact, more than 80 percent of uninsured Americans are either workers or live with workers, and among uninsured workers, 40 percent are employed by businesses with fewer than 25 employees.[51] While the lack of insurance coverage is not exclusively a small-firm problem, small businesses generally have fewer resources on which to draw to pay for such coverage. Therefore, a major policy question for our health care system is how to encourage and enable more employers—and small employers in particular—to offer health care coverage to their employees.

Some policy makers believe that if so many employers truly wanted or were able to cover more employees, workers would not comprise such a large portion of the uninsured population. Therefore, they favor an expanded Medicare- or single payer-type solution. But I strongly prefer an approach that would build on the good that so many employers in this country are already doing. Over time, through working with insurers and employee benefits managers, many employers have developed health insurance packages that are both attractive to their employees and reasonable in cost for themselves. Employers also have been a driving force behind health care quality improvement. Retaining innovative employers as key players in the health care system likely would be crucial to the success or failure of any large-scale effort to increase the number of insured workers.

Of course, building on the employer-based model to cover all private-sector employees would require some level of compulsory cov-

[51] Garrett, Bowen, Len M. Nichols, and Emily K. Greenman. *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* Washington: The Urban Institute, September 1, 2001, pp. 2, 5. All of the data compiled in this study are based on an examination of "non-self-employed workers ages 18–64 from a combined sample of the February and March 1999 Current Population Survey (CPS). Like the study, this proposal would apply only to non-self-employed workers (see footnote 12).

erage by employers, which would likely be met with the now customary blend of skepticism, protest, and threats of wage and job losses. Nonetheless, I believe this resistance could be overcome with the right policy.

To bridge the gap between the two paradigms of universal coverage and move from voluntary employer-provided insurance toward mandatory employer-provided insurance, a market-based framework should be created, with flexible rules that pay homage to the differences among employers as well as a long implementation period. This solution would not only reverse the current trend of static or shrinking employer-based coverage and cost shifting to employees; it also would expand insurance coverage more broadly to all private-sector employees and possibly further. It would give some employers, whose business sectors historically do not offer health benefits to their employees, the opportunity to do the right thing for their workers without leaving themselves at a competitive disadvantage.

To find this potential solution, one need only look to the Clean Air Act for guidance and precedent, transferring (with appropriate adaptations) its logic and lessons learned to the health care sector for the benefit of all working Americans.

The Clean Air Act's Acid Rain Control Program and Allowance Trading

The Clean Air Act, codified as 42 U.S.C. 7401 *et seq*., was enacted to protect the environment and human health from emissions that pollute the air. Amendments to the Act in 1990 included establishment of an acid rain control program (title IV), which sets national goals for reducing annual sulfur dioxide emissions from power plants, by far the largest contributors to such emissions.

These emissions reductions have been imposed in two steps, with facilities generating larger amounts of sulfur dioxide having to meet specific emissions caps beginning in 1995 and all facilities having to meet a more stringent cap by 2000. As of the beginning of 2001, compliance had been close to 100 percent.[52]

The acid rain control program adopted a unique approach to emissions reduction.[53] First, it established an overall emissions cap that sets a nationwide limit on pollutant emissions. Second, it allocated those emissions to individual sources and allowed trading between them. As described by the General Accounting Office (GAO):[54]

> Unlike the traditional command-and-control approach, in which the regulator specifies how to reduce pollution or what pollution control technology to use, title IV gives utilities flexibility in choosing how to achieve these reductions…. Title IV also allows trading in emission allowances. Based on formulas in the law, each utility receives a fixed number of allowances. Specifically, an allowance is an authorization to emit 1 ton of SO_2. Once the allowances are allocated, the act requires that annual SO_2 emissions not exceed the number of allowances held by each utility plant. To meet this requirement, a utility can buy allowances, in effect paying other utilities to reduce SO_2 emissions below their allowed levels. For some utilities, buying allowances costs less than other approaches.

Utilities also can "bank" extra allowances for future sale or use.

Sound Theory Behind Cap-and-Trade Programs Underlies Success

Emissions cap and allowance trading programs achieve social goals while providing businesses with flexibility that traditional forms of regulation do not. The mandatory emissions cap achieves the social benefits by requiring firms to reduce pollution. The trad-

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[52] *Acid Rain Program: Annual Progress Report, 2000*. Environmental Protection Agency, Document EPA-430-R-01-008, 2001.

[53] A similar approach has been adopted for greenhouse gas emissions in legislation authored by U.S. Senator Joseph Lieberman (D-CT) and John McCain (R-AZ). See S. 139, "Climate Stewardship Act of 2003".

[54] General Accounting Office. *Allowance Trading Offers an Opportunity to Reduce Emissions at Less Cost*. Washington: GAO, December 1994, p. 2.

ing provisions allow firms to minimize their compliance costs.

More direct regulation results in higher compliance costs because it imposes identical or similar requirements on businesses without regard to their varying sizes, economic sectors, geographic areas of operation, or financial positions.[55] In contrast, cap-and-trade approaches respect these differences among firms by providing an environment in which national goals are set, but allowing firms to achieve these reductions in a variety of ways and by different timetables.

Cap-and-trade programs generally work as follows: First, an overall cap is established to set a national goal. In the context of this proposal, the goal is to increase the number of privately employed workers who have health insurance. That goal is expressed here as a decreasing cap on the number of uninsured workers and a corresponding increasing floor in the percentage of covered workers.[56]

Second, allowances are allocated to businesses. Each firm is allotted a certain number of allowances per year, according to a statutory formula and a firm's individual experience. An allowance is defined as an authorization not to do something—in this proposal, an authorization not to provide health insurance for one employee for one year. Once allowances are allocated, the annual number of uninsured, private-sector employees nationwide cannot exceed the number of allowances distributed to private-sector employers. If an employer is not able to insure a sufficient number of its employees to comply with its allowance allocation, the employer can buy allowances from other employers, effectively paying other firms for the right to insure fewer employees than the employer is required to by law.

The intended effect of allowance trading is to minimize compliance costs for employers. Trading allows firms whose financial position is relatively weak to literally buy time through the purchase of allowances and delay their compliance with statutory targets when the cost of an allowance is cheaper than insuring an employee. This flexibility for employers in allowance holdings and timing is the linchpin of this proposal.

Under this proposal, employers also would have the freedom to design health benefits packages. However, these benefits packages would be required to equal a specified minimum actuarial value, and employers would be required to cover at least 50 percent of employees' premiums. Furthermore, to help small firms pool their risk and increase their purchasing power in the private insurance market, state-based mandatory purchasing pools would be established for firms with fewer than 25 employees.

Of course, employees would be the real beneficiaries of this proposal. Workers earning up to 200 percent of the federal poverty level (FPL) would receive premium subsidies on a sliding-scale basis to cover some or all of their employee share of premiums, and, ultimately, all private-sector employees would be insured. Moreover, if employer compliance costs were lower than expected, more employees likely would receive benefits more quickly.

Translating Allowance Trading for the Private Health Insurance Market

Obviously, utility emissions are not the same as uninsured employees, and the strategies that utilities and other types of businesses may use to abate these problems also are very different. Moreover, emissions are acts of commission, not omission, as is the case with an employer that does not provide health in-

[55] *Overview and Issues on Emissions Allowance Trading Programs*. Statement of Peter F. Guerrero, Director, Environmental Protection Issues, Resources, Community, and Economic Development Division, General Accounting Office, July 9, 1997, p. 2.

[56] I have chosen a "negative" approach to constructing the cap—that is, the number of uninsured workers—because the traditional concept of allocating allowances to businesses is inherently "negative." Allowances are given to businesses to permit them to continue certain behavior that the government is otherwise attempting to moderate.

surance for its employees. Nonetheless, translated appropriately for the health care arena, a national allowance trading system has the potential to give private employers the financial and design flexibility to ultimately cover 100 percent of their employees with comprehensive health insurance.

Such a system would have multiple benefits. First, it would help employers to pay for the costs of insuring their workers. Second, it would help level the national health care playing field by reducing regional and economic sector differences in health care coverage. Third, the system could trigger behavioral responses that result in insurance coverage progressing faster than expected under this proposal. Fourth, the market's incentives should stimulate innovations in how employers finance and design employee health plans.

This proposal offers more hope to uninsured employees than many of the alternatives do. The status quo is not sustainable. In today's uncertain economic climate, with rising health insurance premiums, many employers are either dropping health coverage or shifting more health care costs to their employees. But an immediate employer mandate with little flexibility for employers on financing and benefits also would be unworkable and disruptive. This proposal attempts to find a market-based middle ground that would attract supporters across the political spectrum.

The proposal's major features are described below. In writing this proposal, I have attempted to confront a number of major questions that likely would be raised during the course of implementation. However, I have by no means covered all of them. In addition, because this is the first time that such a model has been presented in the health care context (to my knowledge), significant quantitative work must be done to determine the exact levels of funding needed to reach the proposal's stated objectives.

While I believe the allowance-trading model has the potential to provide the nation with a unique solution to the health care conundrum, I do not intend to present this proposal as the only way in which one might use allowance trading successfully. For example, this proposal's approach could be merged with so-called play or pay proposals, in which employers are required either to purchase health insurance for their employees or to pay into a public fund that would finance "fallback" health plans for uninsured workers.[57] Adding the additional option for employers to purchase allowances not to insure their employees would create a new "play, pay, or buy" approach. Allowance trading also could be used in proposals that would make states responsible for designing and administering health care financing systems that provide universal health insurance.[58] Under that type of model, allowances could be distributed to states instead of employers, and states would use and trade allowances during a long implementation period until they ultimately were required to cover 100 percent of their legal residents. As a final example, proponents of an individual mandate approach to providing universal health insurance could fold the allowance-trading concept into their model as well. Individuals could be permitted a transition period before they were required to insure themselves, and, in the meantime, they could purchase allowances through a government-sponsored auction instead. The proceeds from this auction would be used to pay for uncompensated care in the health care system. Thus, my true aim in writing this proposal is to introduce the allowance-trading concept into the mainstream of political and policy debate over health care reform.

[57] For instance, one could use the State Children's Health Insurance Program (S-CHIP) as the basis for a fallback plan.

[58] See Kronick, Richard, and Thomas Rice. "A State-Based Proposal for Achieving Universal Coverage." In *Covering America: Real Remedies for the Uninsured*. Washington: Economic and Social Research Institute, June 2001, pp. 121–34.

Building on Employer-Provided Coverage

This proposal to cover all private-sector workers builds on employer-based coverage by enabling all private employers to eventually afford health insurance for their employees after a long implementation period. During the implementation period, firms would be required to gradually lower their numbers of uninsured workers, according to declining capped levels, to meet minimum employee coverage rate targets. These minimum targets, or "floors," would increase every year. To help firms meet the floors, each year the U.S. Department of Health and Human Services (HHS) would distribute a declining number of "allowances" to firms not to insure specific percentages of their workforces. To the extent that a firm still could not meet such a floor, it could purchase more allowances from other firms or buy them at auction to avoid enforcement penalties. (The allowance allocation and trading system is described in the next section.)

Under this proposal, businesses would not be expected to provide health insurance for their employees any sooner than other firms with similar profiles. However, they would be required to put together health insurance benefits packages that are affordable and attractive to their workers.

While private employer participation would be mandatory, this proposal would give businesses far more flexibility and lower compliance costs than other employer-based proposals would. It would create a market-based mechanism for phasing in universal coverage for private-sector workers. While it may not silence all critics of employer mandates, the proposal would be far less disruptive to the economy than an immediate mandate or other comprehensive reforms would be.

National Coverage Floors

All private employers would be subject to national coverage floors, which would be effective beginning two years following the date of enactment. In the first year of program implementation, the national coverage floor would equal the average number of insured, privately employed individuals over the period 1996–2000 (using the Current Population Survey [CPS][59]). The national coverage floor for the year also would equal the coverage floor for "average-coverage" employers, and corresponding coverage floors for "low-coverage" and "high-coverage" employers would be calculated based on averages in these two groups over the same period. (These three categories of employers are defined and explained below.) HHS would calculate all floors, both as numbers of insured, privately employed individuals and as percentages of the private workforce.

After the first year of implementation, all coverage floors would increase every year by 1.5 percentage points. They would continue increasing until they reached 100 percent, at which point all private employers in a 100 percent coverage category would be required to cover all of their employees without exception.

Using a recent five-year period as a starting point for national coverage floors accomplishes two important policy goals. First, by using past years as a base, it prevents firms from gaming the system through purposely lowering their coverage levels as preparations are made to implement the new program. Second, by using a five-year average, it accommodates for the normal up-and-down swings

[59] While the Current Population Survey (CPS) is not the only source of federal data on the uninsured, it is widely used because it has the largest household sample size and provides credible state-level estimates. Also, among competing federal surveys, the CPS is most often criticized for overcounting the uninsured. Therefore, in the context of this proposal, using the CPS results in greater flexibility for employers: higher numbers of allocated allowances and a longer time frame in which to achieve 100 percent coverage of their employees.

of the business cycle that can affect employer-based coverage.

Based on CPS analyses, one could anticipate that employers would have somewhere between seven ("high-coverage" firms) and 20 ("low-coverage" firms) years to cover all of their employees.[60] For example, looking at national patterns, small firms likely would have a longer transition period than large firms, retail businesses a longer period than manufacturers, and Texas firms a longer period than Pennsylvania firms. All firms also would have the flexibility not to comply with annual coverage floors by buying the right to insure fewer employees, either from other firms or at an annual auction.

Under this proposal, provisions of the Health Insurance Portability and Accountability Act (HIPAA), Employee Retirement Income Security Act (ERISA), and state laws related to employer-provided health insurance would continue to apply. As an important example with particular relevance here, HIPAA's employee non-discrimination rules would remain in effect. Therefore, in deciding which employees to cover each time its floor increases and requires it to cover more employees, an employer would not be permitted to deny an employee eligibility for health insurance due to health factors such as health status and medical history. However, as current law allows, an employer could, in the short term, exclude from coverage part-time workers or workers with fewer than six months on the job. Ultimately, when its coverage floor reached 100 percent (or possibly sooner, since non-discrimination rules likely would not permit the employer to cover some part-time workers and not others), the employer would have to cover these workers, too. But in the short run, the employer could make the same eligibility distinctions allowed today. While these inequities are not ideal, they would be temporary, and they offer a distinct improvement over freezing current inequities in place.

Leveling the Playing Field for Businesses

One important barrier to employers offering health insurance coverage to their employees is that their direct business competitors might not do so. Lowering profit margins for the sake of employee benefits may not be wise if such an action places a business at a competitive disadvantage. Therefore, any employer-based plan to expand health insurance coverage must find a way to level the playing field for businesses of similar size that compete against each other in the same economic sectors or in similar geographic regions.

To achieve this goal, the proposal would group businesses into one of the following categories of employee health insurance coverage: "low-coverage," "average-coverage," or "high-coverage." By definition, "average-coverage" firms would be those groups of firms that provided health insurance for a percentage of their employees that was close (that is, within a certain range higher and lower) to the national average of coverage among all private employers in the years 1996–2000 (using the CPS[61]). "Low-coverage" and "high-coverage" firms would be those groups of firms that provided insurance for either a significantly lower or higher percentage of their employees relative to the national average of coverage among all private employers over the same period. In the future, all three of these categories of employers would be required to cover higher and higher percentages of their employees until they achieve 100 percent coverage. However, firms in the "low-coverage" category, by having a lower level of coverage as a starting point, would have a significantly longer transition period to 100 percent coverage than would firms in the "high-coverage" category.

[60] See, generally, Garrett, Nichols, and Greenman.

[61] See footnote 9.

Firms would be grouped for placement in these categories based on their common sizes, industries, and geography. For size, businesses would be divided into those with 100 or more employees, 25 to 99 employees, 10 to 24 employees, and fewer than 10 employees. For industry type, businesses would be divided based on the classifications of the Current Population Survey Annual Demographic Supplement (excluding "Government"): agriculture, forestry, and fishing; construction; trade; services; mining; transportation and public utilities; manufacturing; and finance, insurance, and real estate. For geography, businesses would be divided by either their state of incorporation or the primary state in which firms conduct their business.

For example, one might find that all construction firms with fewer than 25 employees operating in southern states fall into the "low-coverage" category. In that case, all of these similarly situated businesses would be subject to the same, initial employee health insurance coverage floor (expressed as a percentage of a firm's total number of employees) and the same year-by-year increases in that floor. They would not be disadvantaged relative to each other.

While one could create narrower categories than the three I have chosen, maintaining eight, 16, 32, or more categories with coverage targets increasing into the future could prove to be an undue administrative burden. Three categories should provide adequate flexibility, even to "low-coverage" employers. Also, the progress three categories of employers make in covering their employees over time not only would be easier for regulators to watch but also easier for the public to observe and understand, which would be crucial for engendering popular support for the program. Moreover, establishing where different types and sizes of firms fall among these three categories at the outset is vital for proper categorization of new firms established after the first year of program implementation. Adding more categories would further complicate this process.

Defining "Coverage"

To allow employers to comply with the employee coverage floors and to clarify the program's goals, the meaning of "coverage" should be defined as clearly as possible.

"Employee" for purposes of "coverage" means a full-time, part-time, or contingent (temporary or contract) employee.[62] "Employee," however, does not include dependents of employees. But employers could choose to cover dependents and, in some circumstances, as described below, would be required to cover dependents at the option of the employee.

Covering full-time workers is a major goal of this proposal, since they comprise 71 percent of uninsured workers.[63] But the importance of also requiring businesses to cover their part-time and contingent workers should not be underestimated. Only 73 percent of part-time workers are insured, compared to 88 percent of their full-time counterparts.[64] Despite the fact that their take-up rates are similar to those of regular workers, contingent workers with less than six months of experience are less likely to be eligible for their employers' insurance than recently hired regular workers (41 percent, compared to 70 percent).[65] Moreover, requiring employers to

[62] Under this proposal, the term, "employee," does not include the self-employed, defined as "[s]omeone who is working in a small family business as the owner, or who is working in the family business without pay…." (Garrett, Nichols, and Greenman, p. 4, fn 1). However, self-employed workers would have a one-time option to join the health insurance purchasing pools described in the section on financing.

[63] Garrett, Nichols, and Greenman, p. 6.

[64] Garrett, Nichols, and Greenman, p. 15. The authors also note, "Sponsorship [by employers] is lower for those working less than full-time, but the reason for low coverage is less tied to sponsorship than to eligibility and take-up." Under this proposal, employers could continue to use eligibility rules as a means to determine which employees are covered during program implementation years. However, employers would be judged as being in or out of compliance with coverage floors on the basis of employee take-up rates, not employer sponsorship rates.

[65] Garrett, Nichols, and Greenman, p. 16.

cover full-time employees but not part-time or contingent employees could result in a significant shift in preference among employers from full-time to part-time or contingent workers, with a likely corresponding negative impact on family incomes and benefits.

In this proposal, "coverage" is defined in terms of employee take-up rates, not employer sponsorship, because employer sponsorship only solves about half of the problem. Fifty-nine percent of *uninsured* employees work for employers that do not offer health coverage.[66] However, roughly 21 percent of uninsured employees are ineligible for their employers' health plans (for example, waiting periods for new employees, no coverage for temporary workers), and 20 percent are offered coverage but decline it.[67] Therefore, this proposal deals with both sides of this equation: Employers would be required to sponsor health insurance for their employees but would not have to offer it to all of them at once, and, over time, increasing numbers of employees would have to take up their employers on their offers.[68]

Data from the CPS point to affordability as being the most significant factor in determining employee take-up rates. Take-up rates among employees rise steadily with increases in both income and wages.[69] Moreover, it is difficult to argue that most workers do not want health insurance. As Garrett, Nichols, and Greenman note in their report for the Urban Institute, "The fact that 70 percent of poor workers who are offered coverage take it up would seem to indicate substantial demand for health insurance, since an average employee premium would be a considerable share of their income."[70]

For those employees working less than full-time (fewer than 35 hours per week), employer sponsorship is lower, "but the reason for low coverage is less tied to sponsorship than to eligibility and take-up."[71] According to Garrett, Nichols, and Greenman, "Only 63 percent of those working 20 to 34 hours per week were eligible for coverage, and only 58 percent of those who were offered coverage took it."[72]

This proposal would enable take-up rates to rise over time in two ways. First, since employer compliance with coverage floors would be judged on the basis of employee take-up rates, employers would have a strong incentive to structure health benefits packages with their employees' needs and pocketbooks in mind. Second, employees earning up to 200 percent of the FPL would receive subsidies on a sliding-scale basis to cover some or all of their employee share of premiums. These subsidies would be publicly financed as described in the section on financing.

Employee Coverage from Other Sources

Employees with health insurance from other sources would be deemed to be "covered" by their employers (but not those employees who decline coverage without having other coverage). If an employee were offered coverage through a spouse or partner, the employee could choose whether to receive coverage through the spouse or partner or through his or her employer. Employers would be prohibited from discriminating on the basis of an employee's coverage status when making hiring and firing decisions.

As under current law, employers could not deny eligibility for employer-sponsored insurance based on an employee's eligibility for Medicaid or the State Children's Health Insurance Program (S-CHIP). If an employee's immediate family members were enrolled in different health insurance plans, including Medicaid or S-CHIP, the family could elect to re-

[66] Ibid., p. 7.
[67] Ibid.
[68] As discussed earlier, however, employers would be prohibited from "cherry-picking" among employees on the basis of health factors when deciding which employees to insure.
[69] Garrett, Nichols, and Greenman, pp. 11–15.
[70] Ibid., p. 14.
[71] Ibid., p. 15.
[72] Ibid.

ceive its coverage through either the public program or employer-sponsored insurance. Financial responsibility would be apportioned between the public program and the employer. For example, if the employee chose employer-sponsored insurance for his family, he and his family would receive the same financial contribution from the public program toward health coverage that they otherwise would have received. However, if this contribution fell short of the amount necessary to pay the employee's share of the family's premium, the employee would be responsible for the shortfall. This would encourage employees to pay attention to the price and value of their health insurance options. If the employee were due to receive more funds than necessary to pay the family's premium, the excess amount would flow to HHS for redistribution among the states in accordance with the distribution formula specified in the section on financing.

Employee Benefits and Contributions

Employers would have the freedom to structure employee health benefits packages. However, this freedom would be limited by two important constraints. First, for an employee to be deemed as "covered" by an employer, the employee must take up a health plan with an actuarial value at least as high as the most popular Federal Employees Health Benefits Program (FEHBP) plan among federal workers, inflation-adjusted annually.[73] Second, the employer's share of the health insurance premium must equal at least 50 percent. These requirements aside, employers still would have a strong incentive to craft health benefits that meet employees' reasonable expectations, since employers' compliance with coverage floors would be judged on the basis of employee take-up rates.

To further encourage employers to offer high-quality, reasonable-cost plans, employers would receive allowance "bonuses" for every employee who took up a health plan with the following additional characteristics: the employer's share of the premium equals at least 70 percent; employees' annual out-of-pocket costs are limited to $1,500 for employees earning up to 200 percent of the FPL and $3,000 for employees earning 200 percent of the FPL or more, inflation-adjusted annually[74]; and the benefits package includes a list of certain minimum benefits, such as preventive and developmental screening and treatment services (as determined by a bipartisan, congressionally appointed commission, with this minimum benefits list submitted to Congress under a fast-track procedure requiring an up or down vote without amendment). Two and a half percent of annual allowance allocations would be withheld from employers for the purpose of distributing these bonus allowances. Any of these allowances not distributed as bonuses would be returned on a pro rata basis to the employers from which the allowances were withheld.

Coverage Rules after Full Implementation

After this proposal has been implemented fully, and all private-sector employees have health insurance, the basic coverage rules would continue to apply to preserve the benefits—for employees and the nation's health care system—of reducing the number of uninsured Americans by roughly 80 percent. Employers would have to ensure that all of their employees were covered with health insurance plans with actuarial values at least as

[73] After the first year of implementation, the actuarial value would be inflation-adjusted annually to the Consumer Price Index (CPI) plus two-thirds of the differential between the CPI and Health-CPI over the most recent five years. Doing so would impose greater cost discipline on the health care system than simply using the Health-CPI and would better accommodate the costs of new technologies and scientific breakthroughs than simply using the CPI. In addition, every five years, there would be a new determination of which FEHBP plan is the most popular among federal workers, thereby resetting the base actuarial value from which inflation adjustments would be made.

[74] After the first year of implementation, these caps would be inflation-adjusted annually to the CPI plus two-thirds of the differential between the CPI and Health-CPI over the most recent five years.

high as the most popular FEHBP plan among federal workers. Employers also would be required to cover at least 50 percent of each employee's health insurance premium. In addition, the coverage rules related to coverage from other sources still would apply.

Allowance Allocation and Trading System

At a minimum, an allowance allocation and trading system would, over time, enable businesses to afford the cost of health insurance coverage for their employees. More than likely, it also would help to equalize regional health care differences by providing a national market in trading; trigger behavioral responses that lead to higher rates of insurance coverage sooner than expected under this proposal; and encourage employers to be innovative in the financing and design of employee health plans.

Allowance Allocation

Under this proposal, an "allowance" would be defined as a limited authorization for a private employer not to insure one employee for one year.[75,76] HHS would distribute allowances to private employers annually based on the system described here.

Allowances would not expire until they were used. If not used by the employer to which the allowance was distributed in the year in which it was distributed, the employer could save or "bank" the allowance for future use or sale.

Allowances would be distributed to private employers every year until the coverage floor for their category reached 100 percent. After that point, employers would have to insure 100 percent of their employees without exception. However, any remaining banked allowances these employers had could still be traded until the coverage floors for all categories of businesses reached 100 percent; but once that occurred, all allowances would cease to be valid and marketable. In addition, allowances would be valid only as long as an employer remained in business. When a business is acquired by another entity, thereby forming a new firm, both the market value and obligations attached to the allowances held by the original business would be passed on to the acquiring entity. But HHS would keep a watchful eye for those businesses attempting to structure sham deals for the sole purpose of gaining an advantage under the new system. For instance, the creative shuffling of employees and business operations among subsidiaries to enable a particular subsidiary to be re-classified as a "new" firm in a more favorable category (that is, with a longer implementation period) would be prohibited.

In the first year of program implementation (two years after the date of enactment), all private firms in the same category (that is, "low-," "average-," or "high-coverage") would be allocated the same number of allowances, based on the 1996 to 2000 average numbers of uninsured, privately employed individuals in their categories.[77] Firms would receive allowances irrespective of whether they have sponsored insurance in the past. The total number of allowances available to be allocated would be equal to the average number of uninsured, privately employed individuals over the period 1996 to 2000, likely requiring a pro rata adjustment of allowances

[75] No value distinction between allowances for full- and part-time employees would be made since the cost of insuring an employee does not vary based on his or her full- or part-time status. Also, for accounting and trading purposes, allowances would be divisible into twelfths since health insurance premiums (and thus changes in the status of employees' coverage) are generally paid monthly.

[76] The statute would state clearly that allowances are not property rights to avoid any takings issue if the government were to decide to change the coverage floors in the future. According to the Environmental Law Institute, this provision under the Clean Air Act's acid rain program did not have a dampening effect on the allowance market. Environmental Law Institute. *Implementing an Emissions Cap and Allowance Trading System for Greenhouse Gases: Lessons from the Acid Rain Program.* Washington: Environmental Law Institute, September 1997, p. 60.

[77] See Environmental Law Institute, pp. 37—40.

across the three categories. As mentioned earlier, using a recent five-year period as a starting point would prevent firms from gaming the system in advance, while accommodating for swings in the business cycle that can affect employer-based coverage.

This initial allowance-distribution scheme, operating in conjunction with the coverage floors, also would serve two other important purposes. First, it would function as a quasi maintenance of effort provision. The starting benchmarks for all future, annual increases in the numbers of covered employees would be derived from recent, average coverage levels in the three different categories of firms. Second, by allocating allowances to all employers, the initial distribution scheme would not just help employers offering coverage to their employees for the first time. It also would award allowances to employers that were good corporate citizens in the past by providing health insurance to their employees when they were not required to do so.[78]

After the first year of program implementation, each employer would be allocated a fixed number of allowances at the beginning of every calendar year based on that employer's average number of uninsured employees over the previous five years, that is, on the basis of a five-year moving average.[79] Allowance allocations would be reset every year on this basis and adjusted according to a pro rata share system that matches the total number of newly available allowances in the system in a given year with the national coverage floor and the corresponding categorical coverage floors to be reached. Until they have five years of history under the new program, existing employers would be allocated allowances based on a modified, five-year moving average: one year of actual experience plus a four-year average based on 1997 to 2000 experience of employers in the same category, two years of actual experience plus a three-year average based on 1998 to 2000 experience of employers in the same category, and so forth. New firms entering the system after the first five years of implementation would be allocated allowances in their first year based on the five-year moving average of the number of uninsured employees among firms in the same category during the most recent five years. After their first year, they would be allocated allowances based on a modified, five-year moving average (until they have five years of history under the program): one year of actual experience plus a four-year average based on the most recent experience of firms in the same category, two years of actual experience plus a three-year average based on the most recent experience of firms in the same category, and so forth.

The moving average approach has the advantage of avoiding the political struggles that tend to accompany any attempt to write permanent allocations into law.[80] This approach also would treat new businesses more fairly by allowing them to transition into the system on an equal footing with similarly situated business competitors, receive an allowance allocation, and not be forced to purchase all of their allowances from existing employers to comply with the national coverage floors. A more static model in this context of expanded health care responsibilities for employ-

[78] One could make an argument for eliminating the categories of businesses created in this proposal, favoring instead a simpler distribution of allowances to firms based on their individual historical coverage rates alone. One could contend that, in the context of such a market incentives system, all firms would face a uniform "cost" of compliance in the form of the allowance price. Therefore, regardless of their variations in size, industry, and geography, and regardless of variations in coverage history, firms would be similarly situated competitively because the cost of insuring one more employee would be the same for all of them—that is, the cost of buying an allowance on the market. But there are two problems with this argument. First, in the long run, all employers must buy insurance policies for all of their employees, and the costs of those policies will vary widely from business to business, depending on a business's size, industry, geography, and other factors. Second, an approach based solely on individual firms' coverage histories would effectively penalize those firms that have been good corporate citizens and provided health insurance to their employees when the law did not require them to do so.

[79] See Environmental Law Institute, pp. 41–4.

[80] Ibid., p. 42.

Allowance Allocation and Trading: How the System Would Work in Practice

Jake Jones owns a small business, "Just Jake's," which employs nine workers but does not provide health insurance for any of them. Just Jake's is a small delicatessen located in Athens, Georgia. As a restaurant with fewer than 10 employees located in a state with lower levels of insured workers than the U.S. national average, Just Jake's (and similarly situated restaurants) likely would fall into the "low-coverage" category of businesses under this proposal. Assume that the national coverage floor for that category in the first year of implementation would be 70 percent of employees—the lowest coverage floor and corresponding to the most generous percentage distribution of allowances, relative to the "average-" and "high-coverage" categories. Just Jake's would receive sufficient allowances in the first year of implementation to avoid purchasing insurance for three of its nine workers (33 percent, not 30 percent, since one would round up to whole numbers because one could not insure a portion of an employee). Just Jake's would then have a series of options: the restaurant could buy health insurance for all of its workers and save ("bank") its three employees' worth of allowances for future use or sale; buy health insurance for just six of its workers, for whom it does not have allowances; or purchase six more employees' worth of allowances from other firms or at auction, at a significantly lower cost than purchasing health insurance for six employees. Since the 70 percent floor would rise by only 1.5 percentage points per year, it would be six years before Just Jake's health insurance coverage responsibility increased by one more employee to seven employees, giving the delicatessen ample time to implement business strategies to meet the rising challenge.

Jack Beyer owns a medium-size business, "Hard Sell," which employs 20 workers and provides health insurance for all of them. Hard Sell is a lobbying firm located in Bethesda, Maryland. As a medium-size lobbying firm located in a state with higher levels of insured workers than the U.S. national average, Hard Sell (and similarly situated lobbying firms) likely would fall into the "high-coverage" category of businesses under this proposal. Assume that the national coverage floor for that category in the first year of implementation would be 90 percent of employees—the highest coverage floor and corresponding to the least generous percentage distribution of allowances, relative to the "average-" and "low-coverage" categories. Despite its history of 100 percent employee coverage, Hard Sell still would receive sufficient allowances in the first year of implementation to avoid purchasing insurance for two of its 20 workers (10 percent). Like Just Jake's, Hard Sell would have numerous options. Hard Sell could continue to purchase health insurance for all of its employees and bank its two employees' worth of allowances for future use or sale. It also could lower its employee coverage percentage to 90 percent and use its allowances (or lower its coverage percentage below 90 percent and purchase additional allowances) if Hard Sell unexpectedly lost some clients and decided to save money by dropping some or all of its employees' health insurance as a short-term measure. Nonetheless, Hard Sell would have to plan ahead and be prepared to cover 100 percent of its employees on a permanent basis within seven years.

ers—with a precise formula written into law that allocates allowances to existing firms, as was the case with the acid rain program—could create economic barriers to starting new businesses and negatively affect job creation.

One could argue that a moving average system nonetheless has possible disadvantages. For example, it could reduce the incentive for employers to increase the number of insured workers and bank extra allowances for the future. In theory, that could happen, since allowance surpluses created by employers insuring more workers than required "would be progressively reduced as the allowance allocation is gradually lowered under the moving average system."[81] However, such a result is highly unlikely. The primary factor motivating an employer to insure more employees would be the steadily increasing national coverage floors, not the opportunity to trade surplus allowances, and that has been the experience under the acid rain program.[82]

Another possible disadvantage of a moving average system is the potential to "discourage the trading of…allowances by reducing the predictability of future allocations."[83] However, a five-year averaging period would create "reasonable certainty," since 80 percent of the allowances would be

[81] Ibid., p. 43.
[82] Ibid.
[83] Ibid., p. 44.

guaranteed in the next year, followed by 60 percent, and so forth.[84]

Allowance Trading and Auctions

If unable to reach a statutory coverage floor with its distributed allowances, an employer would be required to either acquire allowances from another employer (or broker or advocacy organization) or purchase allowances at auction. An employer would be in violation of the law and subject to penalty if it did not take either of these remedial actions under such circumstances.

A vigorous market in allowance trading is key to the success of this proposal. Trading would allow firms to literally buy extra time for compliance by purchasing allowances from other firms. Trading also would make compliance cheaper, since buying additional allowances to cover more employees likely would be significantly cheaper than buying more insurance policies. That is because businesses with excess allowances would have a strong financial incentive to sell most of them—allowances would be marketable only as long as the program was in effect, and these businesses would not need more than small numbers of allowances in reserve to protect themselves from potential economic downturns. These businesses would have to sell their allowances at levels low enough below market prices for employee insurance policies to attract buyers. Otherwise, potential buyers, facing annually climbing employee coverage floors, would choose to purchase health insurance for their uninsured employees. Businesses also would need to sell their allowances at levels low enough to compete with sales prices offered by other firms. For example, if the private health insurance premium for a firm to cover one of its employees for one month were $250, the firm might be able to buy an allowance on the market instead for $70.

For an active market in allowance trading to develop, it should operate on a national and not a state-by-state basis for the following reasons: First, national trading would ensure the presence of an active market in allowance trading due to lower transaction costs and the predictability of having one regulator. If each state were allowed to set up its own coverage floors, regulations, and allowance-trading systems, companies would have far greater difficulty assessing the value of allowances, since that value would vary from state to state, depending on the regulatory environment.

Second, national trading eventually would help to even out pre-existing disparities in coverage levels among the various states and regions of the country. For example, Texas firms that have traditionally not covered their employees could buy excess allowances from Pennsylvania firms that have. These Texas firms would still have to move in the direction of higher coverage levels, but they could buy time and flexibility along the way from the Pennsylvania firms. If instead states had their own programs, and trading occurred exclusively within state boundaries, states with relatively low levels of covered employees would likely have weak trading markets with insufficient numbers of firms with excess allowances to trade. That would make it far more difficult for firms in these states to take advantage of the flexibility offered by this proposal to increase coverage for the uninsured at a pace of implementation that is comfortable for them.

Third, national trading would avoid a "race to the bottom" in which firms could rush to relocate to states with the least stringent regulations and most generous implementation periods. Such a result either would exacerbate pre-existing disparities in coverage levels among states or create new ones.

While at first glance this proposal for a national market in allowance trading would seem to leave state governments out of the regulatory scheme entirely, that is not the

[84] Ibid.

case. States would have significant roles to play and a real stake in the program's success. With a combination of federal and state funds, states would have primary responsibility for providing health insurance premium subsidies for privately employed workers earning up to 200 percent of the FPL. They also would establish mandatory purchasing pools for small businesses with fewer than 25 employees.[85] In addition, state governments would have the opportunity to use excess funds to purchase allowances from employers in their state and retire them to reduce their state's number of uninsured workers ahead of schedule. These roles are discussed briefly in the section on financing.

This national market in tradable allowances would be largely unencumbered. Since coverage floors would apply to all categories of employers from the beginning of implementation, all employers could begin trading immediately, which would help foster early trading. Starting some categories (for example, "low-coverage") later would otherwise leave fewer buyers in the market, since employers in those categories would lack the same urgency of other employers to cover their workers.[86] Moreover, anyone could trade in allowances, including states, health care advocacy organizations, and brokers. Such a wide variety of players would enhance the market's dynamism and effectiveness in achieving this proposal's goal of increasing coverage for the uninsured. For instance, over time, health care advocacy groups could purchase allowances from employers and bank them indefinitely (that is, "retire" them), thereby quickening the pace of achieving universal coverage. Employers donating excess allowances to nonprofit health care groups and taking a tax deduction for the contribution could achieve the same effect.

At the beginning of each calendar year, there would be a 90-day reconciliation period during which firms could buy allowances to cover any shortfalls in coverage below their coverage floors in the preceding year. Trading among firms and other entities could occur throughout the year but would be expected to be more intense during the reconciliation period.

In addition, an annual auction would be held in March—before the end of the 90-day period—to help ensure the availability of allowances for small businesses and new firms.[87] The annual auction, planned and coordinated by an organization designated by HHS, would help to provide price signals to the market and stimulate trading in the early years of the new program. Five percent of all allowances would be withheld from employers each year for sale at this auction, and proceeds from the auction would be returned on a pro rata basis to the employers from which the allowances were withheld. Entities holding excess allowances also could sell them through this auction, and any other employer, individual, advocacy organization, or state could buy these allowances.

At auction, private sellers could specify the minimum sales price for their allowances, but the HHS designee would set a minimum asking price for the rest of the allowances. (Under the acid rain program, for example, the Chicago Board of Trade was the Environmental Protection Agency's designee for the first couple of years.) That would enable HHS to "determine the price at which it offers its allow-

[85] Firms of this size employ 40 percent of all uninsured workers and have the lowest rates of employer-sponsored insurance; see Garrett, Nichols, and Greenman, pp. 5, 8.

[86] General Accounting Office. *Allowance Trading Offers an Opportunity to Reduce Emissions at Less Cost*. Washington: General Accounting Office,, December 1994, pp. 63–4.

[87] In the acid rain program, auctions are now virtually irrelevant. Private allowance markets are very active with year-round trading, and prices have never reflected market power by large businesses. Concerns at the time of the program's inception that big firms would "horde" most of the allowances proved to be unwarranted; see Swift, Byron. "How Environmental Laws Work: An Analysis of the Utility Sector's Response to Regulation of Nitrogen Oxides and Sulfur Dioxide Under the Clean Air Act." *Tulane Environmental Law Journal* (Summer 2001): 342–43.

ances with the assistance of market experts, in much the same way that a privately held company arranges the price for its initial offering of stock with a 'market maker' or expert."[88] HHS thus could ensure that its "asking prices were not so low as to encourage potential buyers to bid less than they would in a competitive market."[89,90,91]

Allowance-Tracking System

HHS would establish an automated allowance-tracking system to conduct or track all allowance issuances, deductions, and transfers. The system would track allowances held by all employers, individuals (for example, brokers), organizations, and states. It would give HHS the ability to monitor compliance with coverage floors and thus ensure that actual uninsurance levels do not exceed available allowances.

To help HHS accurately track coverage levels, employers would be required to report additional, standardized information as part of their quarterly federal tax returns.[92] Employers would report all trades and the prices at which allowances were traded so that market participants could operate in an informed market. They also would report employee hires, terminations, and resignations, since the number of employees would have a direct impact on employer compliance with required employee coverage levels. The Internal Revenue Service (IRS) would be required to share this additional information from the returns with HHS.

In addition, individuals (for example, brokers), organizations, and states would be required to report all allowance trades and prices directly to HHS. They would submit this information quarterly in a standardized, electronic format developed by HHS.

Allowance-trading information gleaned from individuals, organizations, states, and employers (but not information about hires, terminations, and resignations) through the allowance-tracking system would be made public. In combination with the penalty provisions (discussed below in the section on enforcement), this public information would aid in creating a compliance system that is transparent and virtually self-enforcing.[93] Making the trade prices of allowances public also would help to ensure an active market.

HHS would use the allowance-tracking system as the basis for action at the end of the annual 90-day reconciliation period. At that time, HHS would deduct allowances from an employer's allowance holdings in an amount equal to its recorded level of uninsurance. HHS would take enforcement action when employers do not meet their coverage floors.

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[88] GAO, p. 64.

[89] Ibid.; see also Environmental Law Institute, p. 48.

[90] Under the acid rain program's auction, the EPA was not allowed to set a minimum price, creating a situation in which winning bidders paid amounts they actually had bid, generating a range of winning prices. (In contrast, for example, securities auctions "have a single, market-clearing price paid by all winning bidders and received by all sellers" [GAO, p. 53]).) The resulting behaviors of buyers and sellers led to lower prices for allowances than expected. According to the GAO, "Sellers [had] an incentive to place offers as low as possible in order to obtain the highest price. Meanwhile, buyers bid lower, knowing that most allowances offered [would] be very cheap, particularly EPA's zero-priced allowances… .According to utilities active in the market, the prices paid at the auction discourage[d] potential trades or unnecessarily delay[ed] allowance transactions because buyers want[ed] to obtain allowances at the low prices reflected in the auction, while sellers [found] those prices unrealistic and below their costs of reducing emissions" [GAO, p. 54].

Thus, the lesson learned from the early years of the acid rain allowance auction was that without one winning auction price, there is market uncertainty, lower trade volume, and less potential to reduce the costs of compliance with the law. That is why different auction rules are proposed here.

[91] Some lawmakers now view auctions as the best allowance allocation approach in the context of some of the environment's most stubborn pollutants. U.S. Senator James Jeffords (I-VT) has introduced the "Clean Power Act of 2003" (S. 366), which would auction 100 percent of the available allowances. This approach is popular with economists and environmentalists, because it avoids any need for allocation formulas and creates revenue that can be used for other purposes. However, the approach has not gained broad support, since businesses dislike the idea of needing to buy all of their allowances instead of having some distributed to them for free. For the same reason, businesses also likely would reject this approach in the health care context.

[92] Most employers would include this information on Internal Revenue Service Form 941 (Form 943 for agricultural employers).

[93] See Environmental Law Institute, pp. 53–5.

HHS would establish user fees to help the agency cover the costs of operating this tracking system and to further support achievement of this proposal's coverage goals. Employers would pay a set fee to HHS for each allowance distributed to them by the agency. The user fees would be sufficient to handle the heavy trade volume at the end of the year. Efficient and accurate tracking not only would improve compliance monitoring but also would reassure market participants.[94]

The fact that allowance tracking and trading would occur on a national level does not mean the program would become an undue administrative burden. The allowance-tracking system for the acid rain program, after which this proposal is modeled, has been implemented by fewer than 10 EPA employees, and the entire program by fewer than 100.[95]

Tax Treatment and Allowance Trading

During the 1990s, the IRS ruled that EPA's allocations of allowances under the acid rain program were not taxable.[96] That meant that an allocated allowance had a zero cost basis, leading to a large capital gains tax liability for firms when that allowance was later sold. The zero-cost-basis ruling might have been a contributing factor to low trading volume in the early years of the acid rain program, though the General Accounting Office (GAO) believes it was a minor one.[97]

This proposal would permit the market to assign a cost basis to the allocations. Doing so would provide sources with a tax deduction on the fair market value of their allowances when they donate the allowances to nonprofit, health care advocacy organizations.[98] Many of these organizations would be interested in collecting donated allowances for the purpose of retiring them. This policy thus would encourage allowance donations and almost certainly help to buy down uninsurance levels ahead of schedule. Five years after enactment of the acid rain program, for example, 35,000 allowances already had been donated—without the encouragement of tax deductions.[99]

If this approach were adopted, there would be a downside: On distribution, allowances would become federal tax expenditures.[100] Nonetheless, this approach should be considered seriously due to its potential benefits of fostering early, active trading and encouraging early buy-down of uninsurance levels.

Regulatory and Enforcement Authority

HHS would promulgate nearly all regulations necessary to implement this proposal.[101] It also would have the authority to monitor and certify compliance with the new law and conduct on-site visits in an investigative capacity. Moreover, it would have the authority to issue orders requiring compliance and to impose penalties for violations of the law's requirements.

As mentioned earlier, there would be a 90-day reconciliation period at the beginning of each calendar year, during which firms could buy allowances (directly from other firms or at auction) to compensate for any shortfalls in coverage below their coverage floors in the preceding year. If there were insufficient allowances to cover a floor shortfall at the end of the reconciliation period, an employer would be subject to an automatic penalty per employee not insured below the coverage floor. This penalty would equal three times the average annual cost (during the calendar

[94] GAO, p. 65.
[95] Environmental Law Institute, p. 55.
[96] Ibid., p. 60.
[97] GAO, pp.57–8; according to the GAO and the Environmental Law Institute, the major cause of low market activity in the early years of the program was the lack of market transparency and information.
[98] Environmental Law Institute, p. 61.
[99] Ibid.
[100] To address this concern, it would be possible to draft the law so that no cost basis attaches to an allowance until after the federal government has distributed it.
[101] The IRS would design new forms to accommodate the information requirements of this proposal and would be required to consult with HHS in doing so.

year in question) of insuring an employee in the state in which the firm is located with insurance that meets the requirements of the new law. In addition, employers not meeting their coverage floors would have their allowance holdings reduced in the next year by one-twelfth of one allowance for each employee per month not insured below the coverage floor. Similar penalties under the acid rain program have been very effective in promoting compliance. Even in the first two years of the program (1995 to 1996), when the trading market was not particularly active, all utilities complied with the emissions cap.[102]

HHS also would impose penalties on firms that try to game the system with methods that cause "leakage." For example, when firms permanently shut down all or some of their operations, or lay off employees, a corresponding number of allowances would be confiscated and retired. This provision would remove any incentive firms otherwise would have to behave badly and then reap a windfall. Larger firms also would be penalized for breaking up into smaller firms for the primary purpose of enjoying a lower coverage floor and a longer phase-in period. Additionally, HHS would have the authority to assess penalties on employers that discriminate on the basis of an employee's coverage status when making hiring and firing decisions.

In addition to HHS action, citizen suits would be permitted, against both employers alleged to have violated the coverage floors and HHS when the agency is alleged to have failed to perform an action that is not discretionary under the new law (for example, to promulgate required regulations).

Financing

To make states true partners in this national effort and give them a stake in a positive program outcome, a portion of federal user fees (the portion remaining after covering the costs of establishing, implementing, and maintaining the allowance-tracking system, but not covering the costs of any new full-time HHS employees), all revenues from penalties and increased or new federal "sin" taxes, and an amount from general revenues specified by statute would be distributed annually to the states on the basis of their relative numbers of uninsured, private-sector workers. In accepting these funds, states would agree to match them at their Federal Medical Assistance Percentage rates.

States would be required to use as much of these funds as necessary to subsidize the employee share of health insurance premiums on a sliding-scale basis for low-income workers earning up to 200 percent of the FPL. States would use remaining funds to establish state-based, mandatory purchasing cooperatives for small businesses with fewer than 25 employees. If there were still funds available, states could develop ways to insure non-working adults and children who are ineligible for Medicaid or S-CHIP. They also could buy excess allowances from firms in their state and retire them to reduce their state's number of uninsured workers ahead of schedule.

Since 59 percent of uninsured workers have incomes below 200 percent of the FPL,[103] revenues from user fees and penalties would not be sufficient to fully fund this proposal. In the first year of implementation, when only small numbers of employees likely would be added to the rolls of the insured, user fee and penalty revenues might be adequate. But as employers were slowly required to cover higher and higher percentages of their workers, additional sources of funding would be necessary to help employees below 200 percent of the FPL afford coverage, perhaps $40 billion to $55 billion a year for these employees' shares of premiums.[104] That is why a core

[102] Environmental Law Institute, p. 59.

[103] Garrett, Nichols, and Greenman, p. 6.

[104] The high end of the $40 to $55 billion range is a rough estimate based on employers covering only 50 percent of

amount from general revenues would provide the majority of financing for this proposal—to ensure the existence of a stable and sustainable funding stream.

However, significantly increasing or creating new federal "sin" taxes could reduce the amount from general revenues required to fund this proposal. For example, a $2 per pack increase in the federal cigarette tax (from $0.39 to $2.39), as recommended in February of 2003 by the HHS Interagency Committee on Smoking and Health, would generate $28 billion a year. Such a tax would have the added potential benefit of improving public health.

User Fees

HHS would charge user fees on a per allowance basis upon distribution to each employer receiving allowances. While either Congress or HHS could determine the exact amount of the fee per allowance, the fee should be low enough to ensure that "low-coverage" firms could afford it without undue hardship.

Low-Income Subsidies

States would have to ensure the availability of sufficient funds to help low-income workers earning up to 200 percent of the FPL pay for their employee share of health insurance premiums on a sliding-scale basis before spending resources from this program on small-business purchasing pools or other activities. States would subsidize 100 percent of the employee share of premiums for workers with earnings below 100 percent of the FPL, 90 percent for workers with earnings 100 percent to 149 percent of the FPL, and 80 percent for workers with earnings 150 percent to 199 percent of the FPL.

Low-income subsidies are established as a priority in this proposal because, as discussed earlier, employer eligibility rules and employee take-up rates contribute to employees' lack of insurance as much as employer sponsorship does, particularly among lower-income workers. Moreover, as Garrett, Nichols, and Greenman conclude in their study for the Urban Institute, the most efficient health insurance subsidies in the employment context are targeted to low-income workers, not their employers. The authors found that to be the case for two reasons: one, employer benefits are spread over all firm employees, regardless of need, and, two, giving the lion's share of workers "stronger demand for health insurance and the wherewithal to trade wages for tax-preferred employer contributions" encourages more firms to sponsor health insurance.[105]

Numerous states already have experience providing subsidies to low-income workers to help them afford the costs of their employer-sponsored insurance. For example, Iowa, Massachusetts, Mississippi, Pennsylvania, Texas, and Wisconsin operate federally authorized Health Insurance Premium Payment programs, which subsidize enrollment in employer-sponsored health insurance for Medicaid-eligible employees and their families.[106]

Health Insurance Purchasing Cooperatives

After ensuring the availability of sufficient funds to subsidize low-income, privately employed workers, states would use remaining funds to establish state-based, mandatory purchasing pools for firms with fewer than 25

employees' premiums. The low end is a rough estimate based on employers covering 70 percent. Given current employer premium contribution data and incentives provided under this proposal (that is, bonus allowances), the lower end of the cost range may be more realistic. Moreover, covering the full 30 percent share of employee premium costs (in the case of employees earning less than 100 percent of the FPL)—or even the 50 percent maximum allowable employee share—would not be a bad deal for the federal and state governments. Currently, when individuals with similar incomes are enrolled in low-income programs for the uninsured, federal and state governments pay 80 percent to 100 percent of their premium costs. (For current employer coverage data related to premium contributions, see Gabel, Jon et al. "Job-Based Health Benefits in 2002: Some Important Trends." *Health Affairs* [September/October 2002]" 143–51].)

[105] Garrett, Nichols, and Greenman, p. 27.

[106] Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer. *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs.* The Commonwealth Fund, February 2001.

employees. Firms of this size employ 40 percent of all uninsured workers and have the lowest rates of employer-sponsored insurance.[107] Purchasing pools would help these firms to gain purchasing clout and potentially leverage a choice of health plans for their employees. Making the purchasing cooperatives mandatory for these businesses also would enable them to spread their risk without the opportunity for firms with the healthiest employees to abandon the pool in favor of testing market waters on their own.

In addition, self-employed individuals, who are not otherwise covered by this proposal, would be given a one-time option to join these purchasing cooperatives.[108] This option would allow the self-employed to take advantage of the purchasing power and risk pooling inherent in the mandatory cooperatives in exchange for agreeing not to disrupt the cooperatives' stability by cycling in and out to their individual benefit.

Conclusion

This proposal represents a novel approach to achieving health insurance coverage for all privately employed workers. While all employers would be required to participate in this new program, the proposal would give them the tools, flexibility, and long implementation period needed to meet the target goals.

This is a realistic proposal, but like any policy model, it has potential weaknesses. First, while the public could easily understand the program's ends (that is, coverage floors), the means (marketable allowances) would be more difficult to explain. Relative to the Clean Air Act's program to reduce acid rain, this program to increase health insurance coverage would affect individuals more directly, particularly their pocketbooks. Therefore, most Americans would want to understand the details and what impact those details would have on them and their employers. Policy makers would need to make a concerted effort to engage and educate the public about the new mechanisms that could deliver on the promise of health coverage for every private-sector worker.

Second, the public would need to be willing to live with disparities in equity in the short term. All workers would end up in the same place. But along the way, just like today in America, whether one would have health coverage, and how good or expensive that coverage would be, would depend on for whom one worked and where one lived. Again, a strong public information campaign, to ensure that Americans understood the program and to counter political opposition that could develop during the long implementation period, would be of the utmost importance.

Third, as mentioned at the outset, the exact levels of funding needed to reach the proposal's objectives are unknown. This is a fresh proposal in the health care context, requiring significant quantitative work to achieve a proper cost estimate.

With these possible drawbacks in mind, Congress and the President could consider piloting the proposal in a limited number of states that wished to participate. However, such a pilot program would need to involve a representative sample of states from all geographic regions to give policy makers an accurate glimpse of the real potential of a national, allowance-trading program.

As stated earlier, the promise of allowance trading does not rest on the specific design of this proposal. Under a "play, pay, or buy" approach, small firms could decide to pay into a public fund to finance "fallback" health plans for their uninsured workers instead of shopping for additional allowances from other em-

[107] See Garrett, Nichols, and Greenman, p. 5.

[108] Individuals who are self-employed on the effective date of this proposal would be required to make this election within 30 days following the effective date. Those who become self-employed after the effective date would be required to make the election within 30 days of their change in employment status.

ployers or brokers. Under a state-based approach, states, not employers, would receive allowances, using and trading them until reaching universal coverage for their residents. Under an individual mandate approach, individuals would have the option of purchasing allowances through a government-sponsored auction as a transitional measure until they were required to buy insurance. Proceeds from the auction would pay for the uncompensated care in the health care system that would exist until universal coverage is achieved. No matter which of these approaches a policy maker might favor, allowance trading has the potential to deliver on the promise of significantly increasing coverage for the uninsured.

Allowance trading would offer more hope to uninsured workers than many of the alternatives would. Neither our current system nor an immediate mandate of any kind is an economically or politically sustainable method of providing employees with health insurance. This plan thus seeks to find a market-based middle ground that would generate support across the political spectrum.

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Seltman

Key Elements

Paul A. Seltman proposes to build on the current employer-based system to expand insurance coverage to all private sector workers. The proposal includes the following elements:

ESTABLISH ANNUALLY INCREASING, NATIONAL COVERAGE FLOORS specifying the percentages of workers that employers must insure.

ESTABLISH AN ALLOCATION AND TRADING SYSTEM IN "ALLOWANCES," which permit employers not to insure limited percentages of their workforces, consistent with the national coverage floors.

MINIMIZE EMPLOYERS' COMPLIANCE COSTS by giving them flexibility in meeting coverage deadlines and designing health benefits packages.

PROVIDE PREMIUM SUBSIDIES for employees up to 200 percent of the federal poverty level.

ESTABLISH STATE-BASED, MANDATORY PURCHASING POOLS for firms with fewer than 25 employees.

ENFORCE COMPLIANCE THROUGH MONITORING AND PENALTIES implemented by the Department of Health and Human Services.

FINANCE THE POLICY WITH FEDERAL GENERAL REVENUES, "SIN" TAXES, USER FEES, AND PENALTIES, distributed to the states with matching requirements.

About the Author

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